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ABSTRACT

Self-assessments of health are important because they appear to be good predictors of future physical health. To examine age differences in self-reports of health, the self-ratings of 149 adults (53.8 percent over 65 years of age; 46.2 percent 64 or younger; average age 57.1) were compared. Subjects were elderly participants in a community exercise program (N=45), attendees of a center for the aging (N=33), and neighborhood residents (N=70) who completed questionnaires on attitudes toward their own health, mood, disability, and specific medical problems. Analysis of results showed that the respondents tended to rate themselves as healthy; 49.3 percent stated they had no chronic health problems, and 79.5 percent stated they had not been sick in the last 2 months and had not had an accident or an injury. The most troublesome problems reported were high blood pressure and arthritis. There were no significant differences between the ratings of exercise program participants and nonparticipants or between ratings of women and men. Younger respondents, however, rated their health more highly than did older respondents. (MCF)

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SELF-ASSESSMENTS OF HEALTH AMONG THE ELDERLY

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In assessing their own health, old people are different from young people, and men are reported to be different from women. In studies in which respondents rated their health themselves, women rated their health more positively (Ferraro, 1980) and reported more health problems than men with similar self-assessments (Fillenbaum, 1979). According to Cockerham et al. (1983), older people rated their health more positively than younger people. This conclusion was based on research in which elderly persons were asked to compare themselves with peers of their age, sex, and "expectations others have of their health." Cockerham attributes these positive ratings to two factors. One is that simply surviving to old age in a state reasonably free of serious illness or severe disability would be evidence of relatively good health. The second is that subjective responses to a health problem tend to be a function of how much of a person's life is disrupted by the condition. The extent of that potential disruption is determined by the level of physical and mental functioning required in a particular social environment. Since elderly people are not required to maintain a highly active level of functioning, they may find it easier to perceive their health as good enough to meet the needs of their environment.

Self-assessment studies have been carried on in different parts of the country, with different size samples, and different instruments, making it difficult to know how comparable the results are. Marcus and Seeman (1981), many of whose questions I copied for the survey I will report in this paper, obtained data from the 1976 and 1977 household surveys conducted as part of the ongoing Los Angeles Health Survey. Cockerham et al (1983) interviewed 660 adults by telephone. Ferraro (1980) used data from a 1973 survey of the low-income aged in the United States.

Self-assessments of health are important because they appear to be "the best predictors of future physical health" (Belsky, 1984). Research by Mossey and Shapiro (1982) indicates that self-rated health has a relationship to mortality that is independent of objective health status. These self-ratings are influenced by cultural expectations (Shanas and Maddox, 1976). In Eastern Europe and in Israel, where health complaints in old age are accepted, fewer people rated their health as good than in the United States, England, and Denmark. Within the United States, self-assessments of health reflect the norms of particular groups relevant to the respondent (Cockerham et al., 1983; Fillenbaum, 1979; Maddox, 1962). Women, for example, tolerate more symptoms for any given rating if they compare themselves to other women (Stoller, 1984).

Since disabilities vary in the degree to which they disrupt everyday life (Myles, 1978), self-reports of health have included reports of specific medical conditions, days spent in bed because of illness or injury, and number of days in which the respondent had to cut down on usual activities because of a health

condition. Data from health surveys typically show higher rates of morbidity among women than men, while mortality data show the opposite pattern. Medical sociologists have several hypotheses to explain women's higher morbidity rates. A key hypothesis is that women experience milder forms of illness and disability. Marcus and Seeman (1981) found that the female/male differences in sick-role behaviors were reduced when they controlled for "fixed role obligations," inflexible role obligations such as employment status. This suggests that with more women working, female/male differences in sick-role behaviors will be reduced or eliminated.

For the past five years, the author has sponsored, financed (through grants) and coordinated a program that provides free swimming for older people in the Bronx in New York City. The program is partly funded by the North Bronx Neighborhood Restoration Association. Previous surveys have studied program participants and other community residents in terms of their attitudes toward the community and toward services provided in the community. The survey reported in this paper added attitudes towards one's own health, mood, disability and specific medical problems to the topics studied. Would the older residents rate their health more positively than the younger residents of the community? Would this be affected by the health-enhancing activities of the program participants? Would women be significantly different from men in evaluating their health?

The survey was conducted in June, 1984. There were 151 questionnaires collected, but two were illegible. Of the 149 questionnaires that were analyzed, 45 subjects were elderly people who participated in the exercise program. Thirty-three were elderly people who attended a center for the aging; they had not participated in the exercise program. Seventy questionnaires were collected from adults in the same neighborhood who were interested enough in the community to attend a meeting of the Community Planning Board.

Questionnaires were distributed and collected at the site of the exercise program over a period of two weeks, in order to include as many of the participants as possible. The non-exercising elderly filled out the questionnaires at the neighborhood senior citizens center. Community activists were asked for their participation before a regular meeting of the Community Planning Board. At this meeting, only the director (busy organizing) did not fill out a questionnaire.

The age distribution of respondents was as follows: 53.8% were 65 and over, 46.2% were 64 or younger. Average age was 57.1. Modal income was "between $5,000 and $9,999," although average income was $17,000. In the sample, 64.2% were female, 35.8% male. The overwhelming percentage of the respondents were married: 66.7%; 16.3% were widowed, 4.8% divorced, 10.9% single,

and 1.4% separated. Significantly, more women than men lived alone ($p<.01$). Of the males, 76.9% lived with a spouse, and 17.3% lived alone. Of the females, 59.6% lived with a spouse, and 31.9% lived alone.

The survey indicates that the individuals surveyed, all of whom were comparatively active people, tend to see themselves as comparatively healthy. Almost half (49.3%) stated that they had no chronic (recurring or continuing) health problem, "a problem that you have all the time and that makes you ill from time to time." 79.5% stated that they had not been sick during the past two months and hadn't had an accident or injury. In terms of their "most troublesome problem," 30.1% were troubled by high blood pressure and 29.9% by arthritis. More people complained about chronic back problems (11.7%), nasal congestion (9.5%), and headaches (8.0%) than about heart problems (7.3%). Only 13.5% stated that they had had to stay in bed all or part of any day because of illness or injury during the past two months, although 16.8% stated that besides such disability days, there were days when they had had to cut down on things they usually did because of their health.

Older respondents did not rate their health higher than younger respondents did. There was no significant difference between program participants, and non-exercising elderly people. There was no significant difference between women and men. However, of the respondents who reported no chronic health problem, 66.7% of the non-aged rated their health as "excellent," compared to 23.1% of the program participants and 12.5% of the non-exercising elderly. With a chi-square of 13.14, this difference was significant at the .01 level. This difference in ratings, with younger respondents rating their health more highly than older respondents, was also true of respondents who reported having one chronic health problem.

These low ratings do not seem to reflect a negative response set. The health ratings contrasted with the more positive evaluations aged people gave to their community, compared with younger respondents. Older people had lived in the neighborhood significantly longer ($p<.01$) and rated the neighborhood more highly. This finding might be related to another finding, that older people in this community had significantly higher incomes than the younger adults ($p<.001$). In fact, it was income, rather than age, that was related to differences in attitudes toward particular services in the community, e.g., parking facilities, lunch programs, and transportation.

One factor that may relate to the lower ratings older people with no or one health problem gave to their health than younger people, is level of education. Cockerham et al. (1983) found that the more education a respondent had, the more likely health would be perceived in a positive fashion. The older adults in

this sample had a lower level of education than the younger adults (Reference Note 1).

Another factor is the fact that until recently, standards for how a person should be performing physically have been based on data derived from young adults (Andres, 1979). For example, until the Baltimore Longitudinal Study clearly demonstrated that the practice was unreasonable, diabetes had been diagnosed indiscriminately for all age groups when a person's blood sugar level exceed a certain fixed amount. This criterion had been established by determining what was abnormal for young adults without considering that blood sugar might normally rise with age and that a similar elevation of blood sugar might not have the same pathological significance for the old as for the young (Belsky, 1984). Thus, it is often difficult for the individual older person to know what constitutes feeling good or excellent at his/her age. Older people are often accused of being hypochondriacs. However, psychometric data purporting to show that hypochondriasis increases in the elderly are confounded by real health changes with age. Evidence from longitudinal studies shows that where health complaints increase, they probably reflect veridical reports of changing health status (Costa and McCrae, 1985).

Evaluating one's changing health status is difficult. Over-valuing one's state of health can lead to ignoring symptoms and delaying needed help. For example, approximately half of the elderly persons who are eligible for food stamps fail to take advantage of the benefits for which they are entitled (Hollonbeck and Ohls, 1984). On the other hand, under-valuing one's state of health can lead to excess disabilities (Kahn, 1977), true disabilities and increased dependence.

Historically, there have been more young and middle-aged people than aged. With an increased older population, new norms and expectations can be developed. Communication between older people assists the evaluation process. Communities can offer multi-purpose programs that a) allow the individual to take decisive steps toward better health, b) provide a setting for verbal and emotional exchange among older people, and c) give social scientists an available population for research, to assist in the development of age-related standards. Exercise and nutrition programs that provide social exchange contribute to these goals.

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